PRINT CLEAR

For DWC only: MPN Modification Approval Number Date Notice Received: / /

Notice of Medical Provider Network Plan Modification §9767.8

1. Name of MPN Applicant_____

2. Address

_____

_____

3. Tax Identification Number

__ __ -- __ __ __ __ __ __ __

4.Type of MPN Applicant

☐ Self-Insured Employer ☐ Group of Self-Insured Employers

☐ Self-Insurer Security Fund ☐ Joint Powers Authority ☐ State ☐ Insurer

5. Name of MPN, if applicable: _____

6. Date of initial application approval and MPN approval number:_____

7. Dates of prior plan modifications approvals: _____

8. If the medical provider network is one of the following deemed entities, check the appropriate box:

☐ Health Care Organization (HCO)
☐ Health Care Service Plan
☐ Group Disability Insurer
☐ Taft-Hartley Health and Welfare Trust Fund

9. Name of entity, administrator or other third-party who prepared MPN Modification on behalf of MPN applicant (if applicable): _____

10. Signature of authorized individual: "I, the undersigned officer or employee of the MPN applicant, have read and signed this notice and know the contents thereof, and verify that, to the best of my knowledge and ability, the information included in this application is true and correct."

_____
Name of Authorized Individual Title Phone/Email

_____
Signature of Authorized Individual Date Signed

11. Authorized Liaison to DWC:

Name Title Organization Phone/Email

_____
Address Fax number

Please give a short summary of the proposed modifications in the space provided below and place a check mark against the box that reflects the proposed modification. Please explain whether the modification will adversely affect the ability of the MPN to meet the regulatory and statutory MPN requirements._____

- ☐ Change in Service Area: Provide documentation in compliance with section 9767.5.
- ☐ Change of MPN name: Provide new MPN name.
- ☐ Change of Division Liaison: Provide the name and contact information.
- ☐ Change of 10% or more in the number or specialty of Network Providers since the approval date of the previous MPN Plan application or modification: Provide the name, license number, and location of each physician by specialty type or name of provider, if other than physician.
- ☐ Change of 25% or more in the number of covered employees since the approval date of the previous MPN Plan application or modification.
- ☐ Change in continuity of care policy: Provide a copy of the revised written continuity of care policy.
- ☐ Change in transfer of care policy: Provide a copy of the revised written transfer of care policy.
- ☐ Change in Economic Profiling: Provide a copy of the revised policy or procedure.
- ☐ Change in how the MPN complies with the access standards: Explain what change has been made and describe how the MPN still complies with the access standards.
- ☐ Change of employee notification materials: Provide a copy of the revised notification materials.
- ☐ Other (please describe): Attach documentation.

Submit an original Notice of MPN Plan Modification with original signature, any necessary documentation, and a copy of the Notice and documents to the Division of Workers' Compensation. Mailing address: DWC, MPN Application, P.O. Box 420603, San Francisco, CA 94142.

[DWC Mandatory Form - Section 9767.8 - 09/15/05]